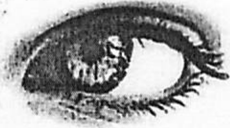

See Life Happen

Eigenbrodt Vision Center P.C.
1950 Edwardsville Club Plaza Drive
Edwardsville, IL, 62025
Office: 618-656-3199
Fax: 618-656-3099

REV A 12.12

Please bring this completed form with you at your next scheduled appointment.

Patient Information

Last Name	First Name	MI	Nickname
Street Address	City	State	Zip Code
Gender ☐Male ☐Female	Status ☐Single ☐Married ☐Student / Child	Birth Date	Social Security #
Email Address	Home Phone	Mobile Phone	
Occupation	Employer / School	Work Phone	
Referred By	Office Use		

Medical Insurance Information

Primary Medical Insurance	Member ID	Group ID	
Responsible Party Information (if not patient) Name (Last, First, MI)	Birth Date	Social Security #	Gender ☐M ☐F
Address (if different from patient)	Phone (if different from patient)	Relationship to Patient	
Employer	Office Use		

Vision Insurance Information

Primary Medical Insurance	Member ID		
Responsible Party Information (if not patient) Name (Last, First, MI)	Birth Date	Social Security #	Gender ☐M ☐F
Address (if different from patient)	Phone (if different from patient)	Relationship to Patient	
Employer	Office Use		

Medicare Patients Only

Secondary Insurance Provider

Responsible Party Name (if not patient)

Patient / Guardian Signature: ______________________ Date: ______________

See Life Happen

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________

Patient Phone Number: ______________________________

Patient Address: ______________________________

Signing this document signifies that you have received a copy of our Notice of Privacy Practices (NOPP).

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose the health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from

Eigenbrodt Vision Center, P.C.

______________________________ ______________
Signature Date

If signing as a personal represenative of the patient, describe your relationship to the patient and the source of authority to sign this form.

______________________________ ______________________________
Relationship To Patient Print Name

Medical History

Name________________________

Please check all that apply (if "Other", please describe)

Date________________________

Constitution	ENT	Neurologic	Psychologic	Cardiovascular	Respiratory
☐ Fatigue Syndrome	☐ Dry mouth	☐ Cerebral Palsy	☐ Anxiety Disorder	☐ Stroke/CVA	☐ Chronic obstruction
☐ Cancer	☐ Hearing loss	☐ Migraine	☐ Depression	☐ Vascular disease	☐ Cigarette smoker
☐ Developmental disabilities	☐ Laryngitis	☐ Tumor	☐ Other	☐ Congestive heart failure	☐ Sleep Apnea
☐ Other	☐ Sinusitis	☐ Epilepsy	☐ Attention Deficit	☐ Heart disease	☐ Emphysema
________	☐ Other	☐ Multiple Sclerosis	☐ Bipolar Disorder	☐ Hypertension	☐ Bronchitis
	________	☐ Stroke, CVA	________	☐ Other	☐ Asthma
		☐ Other		________	☐ Other
		________			________

GI	GU	Musc/skeletal	Integ	Endocrine	Hem/Lymph	Allergy/Immun
☐ Colitis	☐ Kidney disease	☐ Osteoarthritis	☐ Psoriasis	☐ Thyroid dysfunction	☐ Anemia	☐ Sjogren's syndrome
☐ Celiac Disease	☐ STD	☐ Fibromyalgia	☐ Rosacea	☐ Type 1 Diabetes Mellitus	☐ Ulcer	☐ Rheumatoid arthritis
☐ Crohn's	☐ Chlamydia	☐ Gout	☐ Herpes simplex/cold sores	☐ Type 2 Diabetes Mellitus	☐ Large-volume blood loss	☐ Environmental allergies
☐ Ulcer	☐ Herpes	☐ Osteoporosis	☐ Herpes Zoster/shingles	☐ Hormonal dysfunction	☐ Hypercholesterolemia	☐ Drug allergies
☐ Acid Reflux	☐ Nursing	☐ Muscular Dystrophy	☐ Eczema	☐ Other	☐ Other	☐ Lupus
☐ Other	☐ Prostate disease/cancer	☐ Arthritis	☐ Other	________	________	☐ Other
________	☐ Pregnant	☐ Ankylosing Spondylitis	________			________
	☐ Other	☐ Other				
	________	________				

Medications—please list:

________ ________ ________ ________ ________

________ ________ ________ ________ ________

Allergies

☐ Drug—please list: ________________

☐ Environmental

☐ Seasonal

☐ Other________________

Primary Care Physician________________________

Height________________

Weight________________

Past ocular history

☐ Injury
☐ Amblyopia
☐ Glaucoma suspect
☐ Glaucoma
☐ Patching
☐ Retinal degeneration
☐ Surgery
☐ Keratoconus
☐ Age-related macular degeneration
☐ Retinal detachment
☐ Inflammatory disorder
☐ Retinal hole
☐ Strabismus
☐ Cataract
☐ Other
____

Family medical history

☐ Thyroid
☐ Diabetes
☐ Hypertension
☐ Cancer
☐ None

Family ocular history

☐ Retinal detachment
☐ Glaucoma suspect
☐ Amblyopia
☐ Severe hyperopia
☐ Severe myopia
☐ Cataract
☐ Macular degeneration
☐ Strabismus
☐ Glaucoma
☐ None

Social history

Drinking ☐ Yes ☐ No

Amount:____________

Smoking ☐ Yes ☐ No

CIRCLE: cigarettes / cigars / pipe /smokeless tobacco / other

Amount:____________

☐ Never smoker
☐ Former smoker
☐ Current some day smoker
☐ Current every day smoker

Contact lens history

Current lens and powers (if known): ________________________

Wearing schedule: ________________________

Solutions used: ________________________